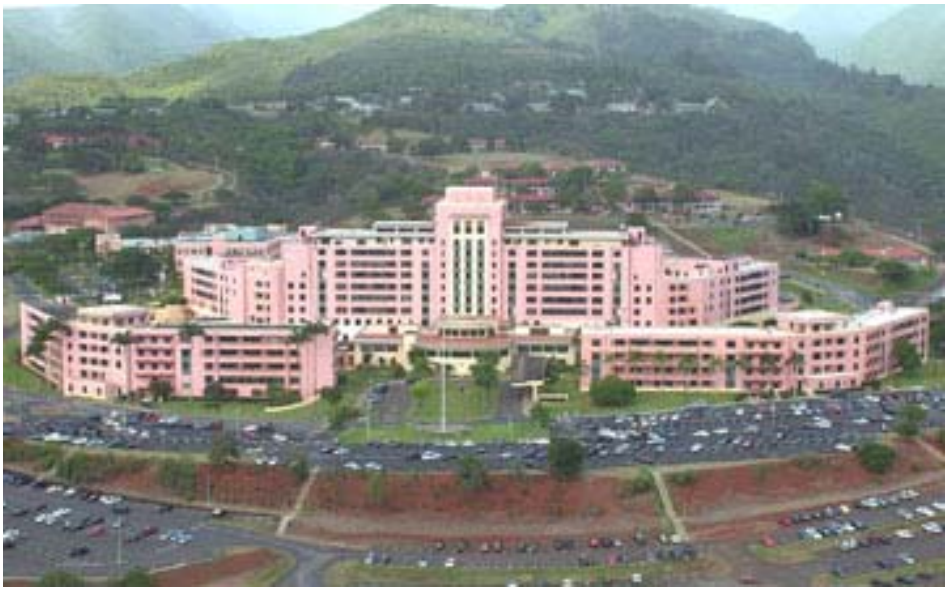
Family Medicine Residency Program
Residency Manual 351-1



1 September 2006

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Residency Manual 351-1

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Medical Training Material

Family Medicine Residency Manual

NOTICE: The information contained in this manual is current as of 31 August 2006. However, policies frequently change. The online manual is the authoritative version and is updated as changes occur.

OPR: MCHK-FMR (Major Dawn C. Uithol)
Supersedes: Family Medicine Residency Manual 351-1, 1 July 2004

The purpose of this manual is to define the standards and policies of the Tripler Army Medical Center Family Medicine Residency Program (hereafter referred to as “the Program”).

In this manual, the personal pronouns “he”, “she”, “him”, and “her” are used alternately, and are intended to include both male and female.

All interns, residents, and faculty within the Program are required to be familiar with and are responsible for the provisions contained within this policy manual.

Additionally, all residents will read and be familiar with the General Requirements for Residency Training, the Special Requirements for Residency Training in Family Medicine, and the American Board of Family Medicine Requirements for Certification, which are available in the Program director's office.

Table of Contents

Chapter 1 – General Information

1-1. **Program Description**. During its second iteration at Tripler Army Medical Center (TAMC), the Family Medicine (FM) Residency program has been training family physicians since 1991. The Family Medicine Residency is a three year, fully-accredited ACGME (Accreditation Council for Graduate Medical Education) program designed to train full spectrum military Family Physicians to meet the diverse needs of the U.S. Army. Care is provided to active duty personnel from all services and their family members, retirees and their family members. These populations encompass all age groups from newborn to geriatric and include obstetrics. Training also encompasses a military unique curriculum as well as a wide range of outpatient and inpatient procedures.

1-2. **Mission Statement**. Train, Prepare and Enable military family physicians to help, to heal, and to guide those people who are serving our country, those who have served our country, and those who will serve our country.

1-3. **Values**.

a. The Army Core Values: Leadership, Duty, Respect, Selfless Service, Honor, Integrity, Personal Sacrifice.

b. Caring. We are compassionate and sensitive to the values of our patients, their families, our community, and each other.

c. Excellence. We constantly look for ways to deliver the highest quality health care to our patients and community and the highest quality education to our learners.

d. Teamwork. We work together to accomplish the education and training goals of the Tripler Family Medicine Residency Program.

1-4. **Residency Organization**.

a. Program Director (PD). This board certified Family Medicine physician oversees every aspect of the training program and is the ultimate authority for the program regarding all training and educational issues other than hospital probation and termination.

b. Residency Coordinator. This individual assists the PD with all administrative matters, keeping program records and statistics, etc.

c. Staff Advisors. Each resident is assigned a staff advisor.

(1) Resident and advisor meet a minimum of monthly on the last Wednesday of each rotation and also as circumstances require.

(2) Advisor and resident, together, review rotation evaluations and progress toward completion of educational and administrative requirements.

(3) They discuss any personal needs and challenges, major life changes or stressors.

(4) Advisors help residents put the specialty training they are receiving into a Family Medicine perspective, and give guidance regarding future plans.

(5) The advisor conducts the quarterly review of the advisee before the FM staff.

(6) The advisor is the military rater of the resident and writes his OER (Officer Evaluation Report).

(7) The advisor writes letters of commendation and makes recommendation for awards as appropriate.

(8) The advisor/rater is involved in any adverse counseling required, formulates letters of reprimand, and develops plans for remediation when required.

d. Family Medicine Faculty. Other faculty supervise and precept residents in the clinic and on the ward as assigned. Counseling and advice is on a less formal basis than with the advisor.

e. Student Coordinator. This faculty member coordinates all the activities of medical students rotating through the department.

f. Chief Residents. These resident-elected and PD approved residents formulate the call schedules, coordinate the lecture series, participate in staff meetings and serve as key liaison between residents and faculty.

1-5. **Department Organization**. The Department consists of the Product Line, FM Service, FM Clinic, Physical Examination Clinic, Emergency Medical Services and Residency Program.

a. The Chief of Family Medicine (or “department chief”) leads the department.

b. The chief of Family Medicine Service (or "service chief") oversees the clinic and residency program.

c. The Clinic OIC (officer-in-charge) is responsible for the day-to-day administrative affairs of the clinic.

d. The Head Nurse is designated to supervise and lead the nurses and medics in their clinical duties.

1-6. **Hospital Graduate Medical Education (GME) Organization**. (For additional information see TAMC Handbook for Residents located on the GME internal Web site.)

a. The Director of Medical Education (DME) is charged with overseeing all the residency and fellowship training programs within Tripler Army Medical Center.

b. The GME Committee (GMEC) is composed of the DME, all the GME program directors, and resident representatives.

Chapter 2 – Academic Requirements

2-1. **Certifications**.

a. BLS (Basic Life Support). By MEDCOM (Medical Command) policy, no physician is permitted to practice medicine in this facility without a current BLS certification. It is each person’s responsibility to maintain a current certification.

b. Residents normally take the following courses during the hospital and FM Orientations, and are expected to maintain certification throughout residency training:

(1) ACLS (Advanced Cardiac Life Support).

(2) NRP (Neonatal Resuscitation Program).

(3) PALS (Pediatric Advanced Life Support).

c. ATLS (Advanced Trauma Life Support) is completed at the 10 day Combat Casualty Care Course (C4) in San Antonio, TX during internship, unless already obtained prior to internship (i.e. USUHS graduates). Certification is required for graduation from residency.

d. BLS, ACLS, NRP and PALS courses can be scheduled by calling the Resuscitative Training Service at 433-2924.

e. All educational courses offered at Tripler Army Medical Center, can be viewed under the Training section of Tripler's intranet homepage.

f. A copy of all current training certifications must be given to the to the residency coordinator for maintenance in each resident's educational folder.

g. ALSO (Advanced Life Support in Obstetrics) is not required but is recommended. The course is held in conjunction with University of Hawaii's Family Medicine Residency Program.

2-2. **Behavioral Science**.

a. Interns and residents meet for one hour weekly in small-group sessions devoted to psychosocial aspects of patient care including doctor-patient interactions, interviewing and counseling skills, the family life cycle, medical ethics, and the emotional health of the physician.

b. A minimum attendance of 80% at these didactic sessions is required.

c. Participation in these sessions is part of the resident's quarterly evaluation.

d. Each resident must complete eight half days of counseling clinic under the supervision of the FM Service's Behavioral Scientist during the second year Psychiatry rotation. Afterward, each resident follows at least one patient or family for approximately six to ten visits and presents a detailed case history to the Behavioral Science group describing the clinical course, showing excerpts from videotaped interviews, and sharing key learning points discovered during these continuity visits.

2-3. **Community Service Projects**.

a. Interns must complete one project.

b. Residents must complete two (2) projects per year.

c. Residents should discuss plans with their advisor, but in general, any valuable community service, whether medical in nature or not, will satisfy the requirement.

d. Examples:

(1) Medical support for community sports events.

(2) Participation in TAR WARS or other educational event for youth.

(3) Providing meals to Fischer House guests (family members of long term patients).

(4) Special Olympics medical attendants or volunteers ("huggers").

(5) Church or civic service.

(6) Family Readiness Group participation (as organizer or officer).

2-4. **Lectures, Presentations, and Meetings**.

a. The Program's educational curriculum includes Morning Report, Grand Rounds and other formal lectures, Team Rounds, Journal Club, Clinic Meetings, Risk Management, and Process Improvement meetings. For individual descriptions of each, see Chapter 4 – Curriculum.

b. Interns and residents must attend a minimum of 80% of these required lectures and meetings to graduate internship or residency or risk an extension in training.

(1) Attendance requirements are based on rotation. This information can be found on the Department Internal Web site under the Family Medicine Residency Program section.

(2) Attendance is calculated as follows:

Present + Excused + No Attendance Sheet
Present + Excused + No Attendance Sheet + Absent

(3) Residents are automatically excused from lectures when on leave, TDY, or an away rotation.

(4) Residents can be excused from lectures and meetings when directly engaged in unavoidable patient care by e-mailing the program director (PD) or associate program director (APD) within three (3) days.

c. Residents must contribute to the formal didactics of the program. The following table shows the required number and type of presentations for each year group:

Presenting Requirements				
	Year	Lectures	Team Rounds	Journal Club
Straight FM	1	0	1	0
	2	1	1	0
	3	3	2	1
Psych/FM	1	0	1	0
	2	1	1	0
	3	1	1	0
	4	2	2	1
	5	3	2	1
Staff		4	3	1

2-5. **Home Visits**.

a. Each resident is expected to complete five home visits during their training before graduation.

b. Completion includes submission of a report of the visit as directed by the Behavioral Scientist.

c. Home visits are scheduled with an attending physician and the Behavioral Scientist during the following rotations:

(1) PGY 1 – Family Medicine Clinic – complete 1 or 2 visits.

(2) PGY 2 – Geriatric (Center for the Aging) – complete 2 visits.

(3) PGY 3 – Community Medicine – complete 2 visits.

2-6. **Obstetric Continuity Patients**.

a. Residents are required to follow and be involved in the delivery of continuity OB patients.

b. Further guidance on continuity OB care is found in Chapter 8.

2-7. **Postgraduate Short Course on Alcoholism**. Completion of this course is normally accomplished during the Family Medicine Clinic rotation in the first year of training.

2-8. **Sedation/Analgesia Course**. During the Family Medicine Orientation month, all interns must complete the certification requirements for Sedation/Analgesia.

a. The course material is found in the TRAINING section on the TAMC intranet home page. At the end of the educational material, there is a test to take and submit for certification.

b. Residents entering the Program at the PGY 2 level must complete this requirement prior to rotating on the FMIT.

c. A copy of the certificate should be turned into the Residency Coordinator.

2-9. **Scholarly Activity.**

a. Complete a scholarly activity project.

b. Present the project for peers and colleagues at a local, regional or national conference.

c. Submit for publication to a peer-reviewed medical journal.

d. Further guidance and resources for research can be found at www.usafp.org/research.htm.

2-10. **Family Medicine In-Training Examination**.

a. Residents must complete the ABFM (American Board of Family Medicine) in-training examination each year.

b. The test is 5 hours in length and is administered the first Friday of November.

c. No leaves or other absences are permitted during this time, except under extraordinary circumstances and approved by the PD.

d. Interns and residents must alert their respective services that they may not take call the night before the exam and can return at 1500hrs on the day of the exam.

e. This exam is used as a tool to guide academic training for the residents. The goals are a composite score of greater than 25th percentile and specialty scores of greater than 20th percentile when compared to their year group nationally.

f. If these goals are not met, the resident and their advisor will devise an academic probation program to remediate and train. This may include but is not limited to the following:

(1) Review of all test questions and answers.

(2) Video tape course review.

(3) Practice Exams from The American Academy of Family Physicians or other source of examination questions.

(4) Core content or Monograph review.

Chapter 3 – Administrative Requirements

3-1. **Officer Evaluation Report (OER) Support Form**. Each year during rotation 1, residents are required to meet with their advisor and or rater to complete their DA form 67-9-1 (available electronically on any department computer) outlining personal and professional goals and objectives for the training year.

3-2. **Rotation Evaluations**. At the end of every rotation, each resident must complete an evaluation of the rotation.

3-3. **Advisor meetings**. Each resident is expected to meet with his advisor monthly on the last Wednesday of each rotation.

3-4. **USMLE/COMLEX III**. It is each resident's responsibility to complete this final phase of testing for licensure. It is this residency's requirement to complete "step 3" prior to the end of internship.

3-5. **License.**

a. Prior to starting any clinical duties, at a minimum all residents must have a training license from Hawai'i.

b. Every Army medical officer is expected to obtain a free and unrestricted license to practice medicine as soon after completion of internship as feasible. Residents who do not have a medical license prior to 30 June of their second year will be reported to the hospital GMEC and placed on hospital-level probation. Information on state licensing organizations is available in the TAMC Handbook for Residents.

3-6. **Chart Room**. Each resident is expected to visit the chartroom weekly for two purposes. The first is for hospital accountability. The second is to complete and/or correct identified inpatient chart deficits. Signing the FM department roster located in the chart room affirms that all assigned charts are complete. Repeat failure to attend to this duty may result in forfeiture of leave or other disciplinary measures.

3-7. **Time Away.** Residents must not exceed the maximum allowed time away from training (see Chapter 12).

3-8. **Army Physical Fitness Test** (APFT). Interns and residents must pass the APFT (Field Manual 21-20, Physical Fitness Training). This test is administered twice a year. Failure to pass results in:

a. Official record flag – no favorable personnel actions such as promotions or awards can occur.

b. Remedial physical training (PT) program.

c. Monthly diagnostic PT tests until the test is passed.

3-9. **Height/Weight Standards.** Interns and residents must comply with Army weight standards. These measurements are typically taken in conjunction with the semi-annual APFT, but

can be taken at any time. Failure to pass results in:

a. Official record flag – no favorable personnel actions such as promotions or awards can occur.

b. Mandatory counseling with the company commander.

c. Mandatory evaluation by Nutrition Care and a primary care physician.

d. Monthly weigh-ins until the standards are met.

3-10. **Birth Month Annual Requirements (BMAR).** One must accomplish a variety of annual tasks during one's birth month. Some of these tasks relate to Joint Commission on Accreditation of Hospitals (JCAHO) training requirements, some to military administrative requirements.

a. BMAR Intranet training. Each resident must complete this online training annually during his/her birth month. Go to http://webserver2/training/index.html and click on BMAR. The training covers such topics as universal precautions, subversion and espionage, and the TRICARE program.

b. Dental Exam. Each resident is required to receive a dental exam yearly during his birth month. To schedule an appointment call 433-3570.

c. Tuberculosis Screening. Each resident is required to undergo yearly TB screening with the PPD test unless she has been previously identified as having LTBI. This test should be administered during the birth month and may be received and read in either the FM Clinic or Allergy/Immunology Clinic.

d. Officer Record Brief (ORB) Review. Each resident must review his ORB during his birth month. To schedule an appointment for the review, call 433-6029.

3-11. **Influenza Vaccine**. All soldiers are required to receive the influenza vaccine annually. Residents receive this vaccine in the Allergy/Immunology Clinic on 4C at the appropriate season when directed.

3-12. **HIV screening**. All soldiers are required to undergo HIV screening every two years. A resident may have her PCM order the test.

Chapter 4 – Curriculum

4-1. **Didactic Curriculum**.

a. Formal didactics are based on a 3-year cycle of medical topics covering the scope of Family Medicine. Each rotation focuses on a different topic.

b. The schedule of topics and lectures for all three years is available on the Departments Internal Web Site under the Family Medicine Residency Program section and clicking FM Share Drive and then clicking on Lectures Team Rounds.

c. Forum descriptions:

(1) *Morning Report* is held Monday through Friday (except the fourth Wednesday of the rotation) from 0730 to 0800. This time is used to present patients admitted to the FMIT and interesting outpatient evaluations. Once a week the FMIT presents "Running of the Board" – a summation of FMIT activity for the week highlighting key learning points the team encountered while caring for the patients on the team. The senior FMIT resident governs the content of morning reports with input from the FMIT staff, the associate PD and the PD.

(2) *Grand Rounds/Core Curriculum* lectures are formal presentations given by residents, faculty, or visiting lecturers. They differ only in attendance requirements.

(a) FM/Pediatric Grand Rounds occur monthly with the responsibility for these lectures alternating between programs.

(b) Military Unique Curriculum lectures focus on special considerations germane to soldiers and their families within the monthly didactic topic.

(c) Team Rounds are smaller group teaching centering either on hands on skills or relatively informal case based learning.

(d) Journal Club is designed to help residents learn to critically review the medical literature. A senior resident or staff selects an article, distributes it, and then leads a group discussion reviewing the article.

(e) Primary Care Series is designed to discuss in group format the latest evidence for a common first degree care issue.

(f) Clinic Meeting involves staff, residents, nurses, ancillary and clerical staff. Clinic issues and processes are discussed in order to improve the practice management of the outpatient family medicine clinic.

(g) Process Improvement involves all clinic providers and nurses and focuses on clinical issues such as practice guideline compliance, pathology results tracking, etc.

(h) Risk Management: Periodically, the department reviews cases that might represent a higher risk liability. The focus is to determine whether standard of care was met and to highlight key learning points for all providers to learn from; the focus is not for blaming or finger pointing.

(i) Residency PT is held the fourth Wednesday of each rotation 0545. It takes the place of Team Rounds and Morning Report. Attendance is taken as for the meetings it replaces.

4-2. **Clinical Curriculum**.

a. The academic year is divided into 13 four-week rotations. Residents rotate through various departments both within and outside TAMC. A key component of these rotations is for all family medicine residents to continue to provide medical care for their own assigned continuity panel of patients in the FM Clinic.

b. Brief descriptions of required and elective rotations:

(1) **First Year Curriculum**.

(a) *Orientation to Family Medicine and the Family Medicine Clinic*. This first rotation of the intern year is designed to introduce interns to the key concepts of family medicine. It places emphasis on the most common problems encountered in the outpatient setting. Each intern assumes care of an assigned panel of ~ 100 patients with four to five half-days each week in the Family Medicine Clinic.

(b) *Family Medicine Clinic*. The intern continues comprehensive care for her assigned patients in the Family Medicine Clinic, makes two home visits, is introduced to outpatient procedures, and participates in Sports Medicine Clinics.

(c) *Family Medicine Inpatient Team*. Under the supervision of staff and senior residents, the intern cares for hospitalized Family Medicine patients, which include a mixture of pediatric, obstetrical, gynecologic, and medical patients. (See chapter 6 for more detailed duties.)

(d) *Pediatric Clinic*. Under the supervision of staff pediatricians, the intern cares for common outpatient pediatric problems, attends pediatric morning report, and takes in-house call on the pediatrics ward an average of every fourth night.

(e) *Newborn Nursery*. Under the supervision of staff pediatricians, the intern assumes responsibility for admission and discharge physicals, neonatal resuscitations, circumcisions, and care of common problems for all newborns not enrolled to Family Medicine. The intern takes in-house newborn call on average once every fourth night.

(f) *Pediatric Ward*. Under the supervision of senior pediatric residents and staff, the intern cares for hospitalized pediatric patients not enrolled to Family Medicine. The intern attends pediatric morning report and lectures and takes in-house pediatric call an average of once every fourth night.

(g) *Internal Medicine Ward*. Under the supervision of senior medicine residents and staff, the intern cares for hospitalized adult patients not enrolled to Family Medicine. The intern attends medicine morning report lectures and takes in-house medicine call an average of once every fourth night.

(h) *Surgical-Medical Intensive Care Unit (SMICU)*. Under the supervision of medicine and surgery residents and staff, the intern assumes responsibility for the care of the seri-

ously ill and post-operative surgical patients assigned to her. The intern attends medicine morning report and lectures and takes in-house SMICU call on average once every fourth night.

(i) *Emergency Medicine*. Under the supervision of emergency medicine staff, the intern works approximately 18-20 shifts in the TAMC Emergency Room, caring for patients who present to the emergency room. At the end of the rotation, interns take a test on assigned readings.

(j) *Labor and Delivery (L&D)*. Under the supervision of OB-GYN residents and staff, the intern admits, monitors, and delivers approximately 20-30 women not enrolled to FM. The intern rounds on post-partum patients that have delivered vaginally, and takes in-house L&D call on average once every fourth night.

(k) *Obstetrics Clinic*. Under the supervision of OB-GYN residents and staff, the intern cares for routine obstetric patients. The intern attends obstetrics morning report and lectures, and takes call once every fourth night on L&D.

(l) *Surgery Ward*. Under the supervision of senior surgical residents and staff, the intern admits and manages patients with surgical problems and assists with their care before, during and after surgery. The intern also spends time in the outpatient surgical clinic learning common outpatient surgical skills, and takes in-house surgical call on average every fourth night.

(2) **Second Year Curriculum**.

(a) *Family Medicine Inpatient Team*. Under staff supervision the R2 cares for hospitalized Family Medicine patients. (See chapter 6 for more detailed duties.)

(b) *Cardiology Inpatient Team (CIT)*. Under the supervision of staff cardiologists, the R2 cares for cardiac patients in the ER, cardiology clinic, telemetry ward, and ICU. The R2 attends medicine morning report and lectures and takes CIT in-house call on average once every fourth to fifth night.

(c) *Neonatal Intensive Care Unit (NICU)*. Under the supervision of senior pediatric residents and staff neonatologists and neonatology fellows, the R2 cares for critically ill preterm and term neonates in the Newborn Special Care Unit at Kapi'olani Medical Center for Women and Children. The R2 attends the NICU rounds, attends all high-risk deliveries, and takes in-house NICU call on an average of once every fourth night.

(d) *Night Float*: The resident takes call and covers the FMIT patients four nights per week. He evaluates patients in the ER, night clinic, and L&D for admission, supervises interns and medical students on call, reports to the Family Medicine staff on call, and coordinates with the FMIT. The resident presents patients he admits at morning report and maintains two continuity clinics per week.

(e) *Orthopedic Clinic*. Under the supervision of senior orthopedic residents and staff, the R2 cares for common outpatient orthopedic problems, rotating through fracture clinic, hand clinic, pediatric clinic, scoliosis and back clinic, joint clinic and cast room. On alternate Friday afternoons the R-2 attends the Tropic Lightning Sports Medicine clinic at Schofield Barracks Physical Therapy or the Sports and Knee clinics at TAMC Physical Therapy.

(f) *Psychiatry Consult-Liaison*. Under the supervision of senior psychiatry residents and staff, the R2 functions as a member of the Psychiatry Consult and Liaison Team. In addition, the R2 sees four to six counseling patients per week working directly with the FM Behavioral Scientist.

(g) *Labor and Delivery (L&D)*. Under the supervision of senior OB-GYN residents and staff, the R2 co-manages the labor deck with the "pit-boss" and supervises interns on the service.

(h) *Gynecology (GYN) Clinic*. Under the supervision of senior OB/GYN residents and staff, the R2 manages acute and chronic women's health issues in the OB/GYN clinic. The R2 also spends time in the operating room and in the infertility clinic. The R2 takes GYN call, which averages once every eighth night. While on call, the R2 carries the GYN pager covering the GYN ward, seeing all GYN consults in the emergency room, admitting GYN patients, and assisting with GYN surgeries as available.

(i) *Dermatology Clinic*. Under the supervision of staff dermatologists, the R2 cares

for common outpatient dermatologic problems and becomes familiar with skin biopsy and suturing techniques.

(j) *Urology and Colposcopy Clinic*. Over the course of the 4-week rotation, the R2, under the supervision of senior urology residents and staff, cares for common urologic problems in the urology clinic as well as learning a vasectomy technique. Also throughout this rotation, the R2 is the primary colposcopist for FM patients in the FM colposcopy clinic. A didactic session is held weekly with an FM staff, as well as time in pathology reviewing specimen slides obtained during the rotation.

(k) *Geriatrics*. This rotation is at the VA Center for Aging (CFA). The R2 evaluates patients as assigned at the CFA, visits a hospice center, completes assigned readings, spends time in the physical and occupational therapy and rehabilitation clinics, and makes a home visit with FM staff and FM Behavioral Scientist.

(3) **Third Year Curriculum**.

(a) *Family Medicine Inpatient Team*. Under the supervision of FM staff, the R3 cares for hospitalized family medicine patients and manages the FMIT. (See chapter 6 for more detailed duties.)

(b) *High Risk Obstetrics*. Under the supervision of senior obstetric residents and staff, the R3 cares for high-risk OB patients in the OB-GYN clinic, on the Ante partum ward, and in the Ante partum Diagnostic Center. The R3 takes FM in-house call, on average every fifth to sixth night.

(c) *Preventive Medicine*. The R3 rotates with specialists in preventive, occupational, environmental, and community medicine, and participates in field visits to daycares, military worksites, and a community health clinic. The R3 makes a family advocacy case visit, prepares and presents a medical threat briefing under the direction of the environmental medicine officer, and conducts one home visit with FM staff and the Behaviorist.

(d) *Sports Medicine*. The R3 sees patients with a variety of sports and military overuse injuries under the supervision of a Sports Medicine Diplomate physician. Additional exposure to musculoskeletal health will be gained through working with PT/OT, podiatry, and Friday afternoon orthopedic knee clinic. A scholarly project suitable for publication or presentation will be completed on a topic mutually acceptable to the resident and Sports Medicine director.

(e) *Orthopedic Clinic*. Under the supervision of senior orthopedic residents and staff, the R3 continues the training and experience received during the R2 orthopedic rotation.

(f) *Surgical-Medical Intensive Care Unit (SMICU)*. Under the supervision of medicine staff, the R3 assumes responsibility for the care of the seriously ill and post-operative surgical patients assigned to her. The R3 attends medicine morning report and lectures, supervises an FM or transitional intern, and takes in-house SMICU call on average once every fourth night.

(g) *Night Float*: The resident takes call and covers FMIT patients four nights per week. He evaluates patients in the ER, night clinic, and L&D for admission, supervises interns and medical students on call, reports to the FM staff on call, and coordinates with the FMIT. The resident presents patients he admits at morning report.

(h) *Ophthalmology and Otolaryngology (ENT) Clinics*. The R3 works with ophthalmology and ENT staff receiving exposure to patients sent to these specialty clinics. The goal is to gain an experience in the kinds of care patients receive from these specialty clinics. The resident may learn what a FM physician can do or patients prior to ordering a consult.

(i) *General Surgery Clinic*. Under the supervision of senior surgical residents and staff, the R3 sees outpatient surgical consults and performs common outpatient surgical procedures.

(4) **Elective Rotations**.

(a) Electives are designed to allow residents to pursue special interests but can be used for remediation if needed. The same rules regarding supervision and evaluation for core rotations apply to electives. No less than three and no more than six electives are allowed in FM residency training.

(b) Number of elective rotations:

(1) There is not an option for elective rotations for interns.

(2) R2s are allowed 1 elective.

(3) R3s are allowed 3 electives.

(c) Existing electives:

(1) Adolescent medicine.

(2) Allergy and immunology.

(3) Anesthesiology.

(4) Endocrinology.

(5) Hematology/Oncology.

(6) Gastroenterology.

(7) Infectious diseases.

(8) Nephrology.

(9) Neurology.

(10) Pediatric neurology/development.

(11) Physical medicine.

(12) Pulmonary.

(13) Radiology.

(14) Research (2 or 4 weeks).

(15) Rheumatology.

(d) A resident may design and develop a new elective by:

(1) Developing appropriate goals and objectives for the rotation, with FM faculty and specialty input.

(2) Receiving PD approval of the elective goals/objectives, schedule and funding (if applicable).

(e) Selecting/scheduling electives:

(1) This should generally be accomplished at least four (4) rotations prior to the start of the rotation.

(2) The PD must approve electives and if timely selection is not made, a FM clinic rotation will be assigned.

(3) A maximum of two (2) electives in the R2 or R3 year may be consumed in remediating a failed rotation (see chapter 10).

(f) Away electives:

(1) Since the program offers all the educational experiences that are needed to meet the general and essential requirements as established by the Family Medicine Residency Review Committee, away rotations must be considered awards for excellent performance.

(2) Neither TAMC nor the Department has the budget to financially support away electives.

(3) Rotations away from TAMC must be approved through the Graduate Medical Education Committee prior to the beginning of the rotation. As a rule, this process takes at least two months. The resident must justify the benefit of the rotation to the Army and to himself, and must show why the same experience cannot be found at Tripler.

(4) A resident may take only one away rotation during each academic year.

(5) Away rotations will not be approved for blocks 11 through 13, or the block of the in-training exam (the first Friday of November).

Chapter 5 – Family Medicine Clinic

5-1. **Operations**.

a. Hours.

(1) The Family Medicine Clinic (FMC) operates from 0730 to 2000, Monday through Thursday and from 0730 to 1600 on Friday.

(2) Active Duty Sick Call is on a walk-in basis from 0730 to 0800, Monday through Friday.

b. Patients.

(1) Service members are typically assigned a sick-call location based on proximity to the unit. In general, the FMC serves the units of TAMC and Fort Shafter.

(2) Any family member or retiree eligible for care at military treatment facilities (specifically TRICARE Prime) may enroll at the FMC – regardless of branch of service.

(3) Only patient enrolled to the FMC will be seen except by special arrangement for the benefit of resident education or a particular special care need of the patient.

(4) Residents' patient panel sizes, clinic frequency, and appointment length varies by year:

Year	Panel	Clinics per week	Patients per half day
PGY 1	100	1	5-8
PGY 2	290	2-4	10-12
PGY 3	520	3-5	10-13

c. Appointments.

(1) Patients call 433-2778 for routine appointments. A reasonable attempt is made to secure routine appointments with the assigned PCM.

(2) Patients with urgent problems may be seen on a same-day basis by any available provider.

(3) The FMC is a no walk in clinic. Patients that walk in will be triaged and given an appointment if not an urgent problem. Those patients who have been determined to have an urgent problem will be given to available staff on administrative time.

d. Telephone Consults.

(1) Patients may leave non-urgent phone messages for their PCM. These are entered as AHLTA TELCONs.

(2) Residents must complete telephone consults within three business days.

(3) If a provider will be unavailable for some reason to answer their TELCONs within the expected time (leave, TDY, away rotation, etc), then a surrogate (fellow resident) must be assigned to ensure all patients receive service within three (3) business days.

5-2. **Procedures**.

a. The FMC supports the following procedures:

(1) Flexible sigmoidoscopy.

(2) Vasectomy.

(3) Neonatal (within 30 days of birth) circumcision.

(4) Minor skin biopsies, excisions, and I&Ds.

(5) Endometrial biopsy.

(6) Graded exercise testing.

(7) Colposcopy with biopsy/ECC.

(8) IUD placement/removal.

b. Referral guidelines for each procedure are available in the file drawer in each exam room and on the M drive. When a patient is referred for a FMC procedure, a FM staff reviews and approves the consult. The procedure clerk then calls and schedules the patient in the procedure clinic.

c. A resident must have staff physically present when performing a procedure unless she has received approval from the PD to independently carry out the specific procedure in question.

5-3. **Supervision**.

a. Precepting. A staff physician is always available for precepting when residents are in clinic. Residents are encouraged to discuss any case they wish to with staff. The following are minimum requirements for precepting:

(1) First Year.

(a) Rotations 1 through 6, all patients.

(b) Rotations 7 through 13, all obstetric patients and patients over 65, and others as needed.

(2) Second Year. All obstetric patients and patients over 65, and others as needed.

(3) Third Year.

(a) Rotations 1 through 6, all obstetric patients and patients over 65, and others as needed.

(b) Rotations 7 through 13, all patients over 65, all non-routine obstetrics and routine obstetrics patients as needed and others as needed.

b. **Records Review**. All residents must submit all of their charts for staff review within 72 hours of the clinic visit.

5-4. **Patient Privacy**.

a. Providers must protect the medical and personal information of patients by:

(1) Complying with HIPPA rules.

(2) Maintaining control of patient records.

(3) Preventing patient access to clinic computers.

b. Chaperones.

(1) All patients have a right to have a chaperone present for any interview or exam.

(2) A chaperone is required when the genitalia or female breasts are examined or exposed.

(3) Since the chaperone protects not only the patient, but the physician as well, a friend or relative of the patient is not an appropriate substitute.

(4) The need for immediate life-saving care overrides this policy.

5-5. **Profiles, Medical Evaluation Boards, and Medical Statements**. (Reference AR 40-501, Standards of Medical Fitness)

a. Temporary profiles.

(1) IAW TAMC policy, profiles for up to three days may be written on DD Form 689, Individual Sick Slip.

(2) Temporary profiles of longer duration must be written on DA Form 3349, Physical Profile.

b. Permanent profiles with "2" as the highest designator must be typed by the FMC secretary and signed by the resident, a staff physician, and the chief of DFMEMS. Permanent profiles with a "3" designator must be signed by the chief of DFMEMS and the DCCS.

c. Medical Evaluation Boards.

(1) The medical board is the Army's mechanism for determining a soldier's medical fitness for retention or for certain types of duty.

(2) The PCM of a patient requiring a medical board is normally the physician responsible for dictating the narrative summary.

(3) Residents should consult with staff when a medical board is required for one of their patients.

d. Medical statements must be submitted through the FM secretary to the chief of DFMEMS and Patient Administration Division.

5-6. **Admissions from Family Medicine Clinic**.

a. When a resident is seeing a patient that may require emergency treatment not available in the FMC, he should alert the attending staff and assure physician-to-physician communication with the ER.

b. When a resident is seeing a patient that may require admission to the hospital, she should first discuss the case with the staff attending and then call the FMIT pager (577-7721).

5-7. **Medical Records**.

a. All outpatient consultations and clinic notes of patients seen by house staff will include the name of the clinic attending physician or the name of the provider with whom the patient was staffed.

b. All entries must be dated and timed and legible.

c. All intern charts must be countersigned.

d. All entries must be legibly signed or signed with a standard name stamp, which includes training year.

e. If a physician makes an error, it must be lined through and initialed. This information must remain readable. Deletion, obliteration, or destruction of medical record information is not authorized.

f. A correction to an electronic entry is made by an electronic progress note entry referencing the wrong entry by date, time, and provider.

g. Physicians must follow the Subjective/Objective/Assessment/Plan format on all entries.

h. Physicians must complete the Master Problem List on the left side of the chart.

i. Physicians may not keep medical records in their possession. They are to be completed within 24 hours of the encounter.

j. It is against DOD policy for patients to keep their own records.

Chapter 6 – Family Medicine Inpatient Team (FMIT)

6-1. **Purpose**. The purpose of the FMIT is to provide quality medical care to assigned patients that require hospitalization. This service also provides opportunities for interns and residents to learn the management of hospitalized patients under the supervision of a staff family physician.

6-2. **Patients**.

a. The FMIT assumes care for the following patients that require hospitalization for non-surgical problems outside of an ICU setting:

(1) Patients enrolled to TAMC FMC.

(2) Patients enrolled to Schofield Barracks Family Medicine.

(3) ALL active duty service-members assigned on Oahu.

b. Care of other patients will be provided by Medicine, Pediatrics, and OB/GYN as appropriate.

c. The FMIT does not care for patients in the NICU, PICU, SMICU, or Intermediate Care Ward, but assumes care when patients transition out of intensive care to the ward.

d. The PCM is notified automatically of hospitalization of a panel patient through CHCS, but the FMIT should also contact the PCM to coordinate care.

e. The PCM (when on an FM call-eligible month) is expected to make informal social rounds on his/her hospitalized panel patients and to stay abreast of their progress.

6-3. **Responsibilities of the FMIT**. The FMIT is typically comprised of four residents (an intern and three upper-level residents, one of whom is the night-float) and a staff physician. Their duties are detailed below.

a. Attending physician.

(1) Assumes overall supervision and responsibility of patient care and resident instruction.

(2) Writes a note on the chart within twenty-four hours of admission and every third day thereafter.

(3) Reviews each chart daily.

(4) Leads teaching rounds at least three times a week and meets with the team each day to discuss each patient.

(5) Supervises any procedures performed by FMIT residents.

(6) Ensures DNR status is discussed with each patient, writes DNR orders and a DNR note as needed.

(7) Ensures adequate check out to on-call staff.

b. Senior Resident.

(1) Assumes primary management of the team.

(2) Supervises rounds.

(3) Reviews and co-signs intern histories and physicals.

(4) Reviews intern daily notes and assures charts are up to date and accurate.

(5) Writes a weekly resident progress note.

(6) Provides continual performance feedback to junior residents, interns, and medical students.

(7) Holds FMIT pagers while other team members attend behavioral science or continuity clinic.

(8) Ensures adequate check out to on-call or night float resident.

(9) Manages FM morning report with guidance from the attending.

c. Junior resident/intern.

(1) Evaluates patients as assigned, presents them to senior resident, and completes the H&P.

(2) Rounds on assigned patients before morning report.

(3) Writes daily progress notes, transfer notes, and off-service notes.

(4) Coordinates tests, consultations, therapy, and discharge planning.

(5) Completes the OP10 and/or narrative summary as needed for dispositioned patients.

(6) Presents patients at morning report.

d. Medical Student.

(1) Cares for her own assigned patients under the direct supervision of an FMIT resident, independent of the FMIT intern.

(2) Evaluates patients as assigned, presents them to senior resident, but does not complete the H&P.

(3) Rounds before morning report.

(4) Writes daily progress notes ***in addition*** *to* the resident progress notes.

e. Night Float Resident.

(1) Evaluates patients as assigned, presents them to staff on-call, and completes the H&P.

(2) Coordinates tests, consultations, and therapy.

(3) Presents patients at morning report.

Chapter 7 – Family Medicine Call

7-1. **General**.

a. The Chief Residents are responsible for developing and posting the house staff call schedule.

b. Call rooms are located on 8C. Call rooms are single-sex in all circumstances.

7-2. **Duties**.

a. Respond to ward calls on FMIT inpatients.

b. Evaluate patients in the ER, FMC, radiology or elsewhere in hospital who may require admission (see paragraph 6-2 for eligible patients), write an H&P, and order appropriate tests and treatments on them.

c. Evaluate OB patients enrolled to FM that present to L&D.

d. Respond to calls from the Physicians' Exchange Service within 30 minutes.

e. Document all encounters properly (inpatient note, outpatient note, consultation form, TELCON).

7-3. **Staff back up**.

a. The on-call resident should call staff:

(1) When a patient requires admission or is dispositioned from the ER.

(2) When another service wants FM to admit a patient but the resident does not believe admission is required.

(3) When a patient presents to L&D with an obstetric complaint.

(4) When the resident has any questions regarding patient management or status.

(5) When urgent workload becomes unmanageable without assistance.

b. If a resident is unable to reach the on-call staff, she should call the PD, FM Service Chief, and Chief, DFMEMS in that order until he/she receives the needed assistance.

Chapter 8 – Family Medicine Obstetrics

8-1. **General**.

a. Longitudinal care of at least ten (10) continuity maternity patients is integral to Family Medicine training and is required by the RRC. This encompasses the provision of antenatal, natal and postnatal care.

b. A resident's panel patient who becomes pregnant will normally be followed by that resident. Additionally, a patient may enroll to a resident panel subsequent to becoming pregnant.

8-2. **Minimums**. The following are the minimum requirements for longitudinal care:

a. Interns: Four patients per year.

b. R2s: Eight patients per year.

c. R3s: Twelve patients per year.

8-3. **Maximum**. Residents should have no more than two (2) deliveries per month/rotation.

8-4. **Supervision**.

a. Outpatient:

(1) OB outpatient visits are staffed with the attending as noted in chapter 5.

(2) Notes are written in the OB chart at the time of the visit. The name of the patient is written on the board in the attending room. It is erased when a staff member has reviewed the note.

(3) Patient visits to L&D for obstetric complaints are discussed with the on-call staff even if the case does not result in admission. Staffing on non-obstetric complaints is not mandatory.

b. Inpatients:

(1) Staff physicians attend every delivery.

(2) Each intern or resident will discuss the condition of his mother/newborn pair with the FMIT staff each day during the hospitalization.

(3) For male infants, circumcisions are staffed/supervised by the FMIT attending.

8-5. **When a Patient Presents In Labor**.

a. The FMIT or on-call resident is responsible for assessment and initial management of obstetric patients presenting to L&D.

b. If there is an indication for admission, that resident will call the continuity physician and retain care for the patient until the continuity physician arrives.

c. If the continuity physician is on duty she will immediately notify her supervisor. In the FMC this is the OIC of the clinic.

d. In consultation with the supervisor, arrangements will be made to cancel or curtail clinics as appropriate to the situation.

(1) It must always be understood that the laboring patient is the resident's highest priority.

(2) Immediate and critical ward issues may ***temporarily*** take precedence depending on the situation.

e. A resident who is pre- or post- call is not eligible to manage the labor and delivery of his continuity patient after hours.

Chapter 9 – Resident Evaluations and Grievance Policy

9-1. Purpose. Residents are continually evaluated to ensure they are meeting minimum training standards, to provide feedback and guidance in support of continued growth, to identify problems early, and to ensure that the program is meeting its requirements. Residents, in turn, provide feedback to ensure fairness and improve the quality of the program.

9-2. **Core Competencies**. Each resident's progress is measured in six areas of development:

a. Patient Care. Does the resident provide compassionate, effective, and appropriate patient care? This includes problem solving, clinical judgment, and technical skills.

b. Medical Knowledge. Does the resident demonstrate knowledge about established and evolving biomedical, clinical, and cognate sciences and its application to patient care?

c. Practice Based Learning and Improvement. Does the resident investigate and evaluate patient care practices? Does the resident appraise and assimilate scientific evidence in improving patient care practices?

d. Interpersonal and communication skills**.** Does the resident demonstrate interpersonal and communication skills that result in effective information exchange with patients, their families, and professional associates?

e. Professionalism. Does the resident demonstrate commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population? This includes proper discharge of administrative duties and military bearing.

f. Systems Based Practice. Does the resident demonstrate awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value?

9-3. **Modes of Evaluation and Feedback**.

a. Rotation Evaluations.

(1) Prior to leaving a rotation, each resident is responsible for seeking feedback and evaluation from their staff supervisor. If an evaluation is not complete within seven (7) days of the end of the rotation, the resident should seek remedy from the supervisor. If this is not successful, the FM advisor should assist the resident in obtaining their evaluation.

(2) The staff physician supervisor for each rotation completes the evaluation for each resident on MyEvaluations.com.

(3) Residents can review these evaluations and add comments as appropriate.

(4) These evaluations are printed and added to the individual training folder.

(5) Each resident reviews his rotation evaluations monthly with his FM staff advisor.

b. FMC Precepting. FM staff work closely with residents in the FMC. They regularly provide informal feedback as they precept. They also provide input to the quarterly review of each resident.

c. Advisor Meetings. FM staff advisors meet at least monthly (usually the last Wednesday of the rotation), with each resident to review rotation evaluations, track progress with academic and administrative requirements, and provide support, guidance, and insight. Advisors provide both formal and informal feedback during these

interviews. They also lead the quarterly review of their assigned residents.

d. Quarterly Evaluation. The progress of each resident is discussed quarterly by the staff, behavioral scientist, PD, and chief residents. In this forum, information from rotation evaluations, behavioral science participation, and advisor meetings is brought together. The staff contributes summary commentary on progress, strengths, and weaknesses. They also track completion of academic and administrative requirements on the quarterly evaluation form, which the resident then initials with her advisor.

e. Yearly Academic Report. This is an annual summary evaluation generated by the PD on the basis of quarterly reports as well as individual interviews with the residents.

f. Other sources of evaluation.

(1) Performance in resuscitative training courses.

(2) Results of the In-training examination.

(3) Performance in the Observed Structured Clinical Exam (OSCE).

(4) Patient and nursing feedback.

9-4. **Resident Evaluations of the Program**.

a. Rotation evaluations.

(1) Residents complete an evaluation of each rotation via MyEvaluations.com.

(2) Split rotations require two separate evaluations.

(3) These evaluations are anonymous and are used to improve the quality of training in the program.

b. Curriculum Review. This meeting of staff and residents occurs on the last Wednesday of each rotation and is an opportunity to bring forward suggestions or alert the program to problems.

c. End of Year Evaluation. This is a comprehensive evaluation by the resident of the faculty, program, clinic, and hospital. It is submitted through MyEvaluations.com and is anonymous.

9-5. **Grievance Policy**.

a. This program adheres to the hospital guidelines for adjudication of complaints and grievances.

b. If an intern or resident feel he is being treated unfairly, or that conditions of training do not meet the training program description or ACGME and RRC guidelines, he should first seek resolution of the problem through (in order):

(1) His assigned advisor.

(2) The PD.

(3) The Chief, DFMEMS.

c. If satisfactory resolution is not achieved in this manner, the resident may present the problem to (in order):

(1) The DME.

(2) The Commanding General.

d. As appropriate to the situation, the resident may call upon the following individuals for redress of grievances:

(1) TAMC Chaplain – 433-5727.

(2) TAMC Equal Opportunity Advisor – 433-5813.

(3) TAMC Inspector General – 433-6619.

(4) TAMC Staff Judge Advocate (SJA) – 433-5311.

Chapter 10 – Remediation, Probation, Extension, Withdrawal, and Termination

10-1. **Fairness**. The program is committed to the impartial and equitable enforcement of academic and professional standards.

10-2. **Overview.** The management of residents that encounter academic, administrative, and professional difficulties in the program is governed by TAMC policy and is discussed in detail in the TAMC Handbook for Residents. The following is an overview of some aspects of the policy.

a. Identification. The PD is responsible to identify residents with deficiency in knowledge, skill, attitude, or professional behavior.

b. Program level remediation.

(1) This measure may be entertained when a resident's performance fails to meet expected standards of knowledge, skill, attitude, and behavior.

(2) The PD and/or advisor documents and provides to the resident a description of the deficiency, the methods imposed to improve the performance, the objective measures that must be met to satisfy the remediation, and the time frame for meeting those measures.

(3) The resident is offered an opportunity to sign a statement acknowledging the remediation.

(4) The resident is offered an opportunity to write a rebuttal.

(5) These documents are placed in the resident training folder.

(6) This is *not* considered an adverse action.

(7) The DME is notified, but no formal presentation is made to the GMEC.

(8) Remediation may not exceed 60 days. It may not be extended or repeated.

(9) Acts of gross negligence or willful misconduct are referred immediately to the GMEC and are not addressed with remediation.

c. Probation.

(1) This measure may be considered for any act of gross negligence, willful misconduct, failure to successfully remediate, violation of UCMJ, or other circumstances deemed significant by the PD.

(2) The PD must notify the resident in writing that probation is being considered.

(3) The resident will be asked to sign a copy of this document for the training file.

(4) The resident will have five working days to submit a written reply and meet with the PD.

(5) If the PD then decides to pursue probation, she submits a request to the DME who convenes a hearing of the GMEC.

(6) The GMEC recommends for or against probation to the DCCS who makes the final decision subject to a single appeal to the commander.

(7) Completion of probation:

(a) The PD may recommend removal of the resident from probation. This action is approved by the DCCS as recommended by the GMEC as above.

(b) The resident may withdraw from the program.

(c) The resident may be terminated (see below).

(8) For details of this process, please see the TAMC residency handbook.

d. Extension of Training. A recommendation for extension of training may be an element of a Probation plan of remediation. It may also be necessitated by absence from training in excess of ABFP limits. This action is approved by the DCCS on recommendation of the GMEC.

e. Termination.

(1) This action may be entertained for grave acts of negligence and willful misconduct, failure to remediate after probation, and two-time non-select for advancement in rank.

(2) The decision is made by the Commanding General on recommendation of the GMEC as proposed by the PD. The decision is not subject to appeal.

(3) For details of this process, please see the TAMC Resident Handbook.

f. Resignation.

(1) A resident or intern may submit a written letter of resignation to the PD.

(2) The PD recommends to the GMEC whether the resident should be considered for future GME.

(3) The resident becomes eligible for immediate reassignment according to the needs of the Army. A resigning resident is typically assigned as a GMO, while a resigning intern is reassigned to another branch to complete his service obligation.

(4) For details of this process, please see the TAMC Resident Handbook.

Chapter 11 – Resident Lifestyle

11-1. **Financial Compensation**. Residents receive pay from the U.S. government according to rank and time in service. Please visit http://www.dod.mil/militarypay/pay/bp/index.html for current figures.

11-2. **Living Quarters**. Active Duty soldiers are eligible for on-post government housing or an allowance for off-post housing in the community. Please see http://www.dod.mil/militarypay/pay/bah/index.html for current rates.

11-3. **Meals**.

a. Meals are available at the Dining Facility at the following hours:

(1) Weekdays:

(a) 0600 to 0900

(b) 1045 to 1400

(c) 1600 to 1800

(2) Weekends and holidays

(a) 0630 to 0830

(b) 1100 to 1330

(c) 1600 to 1730

b. Residents receive BAS (basic allowance for subsistence) and pay for their own meals at the TAMC dining facility. Please see http://www.dod.mil/militarypay/pay/bas/index.html for current BAS rates.

c. Food concessionaires operate on Wing 1C during limited hours.

d. Vending machines are available throughout the hospital.

11-4. **Laundry**.

a. Hospital scrubs and cover gowns are provided in applicable locations.

b. TAMC laundry services will launder uniforms soiled by blood or body fluid during the course of duty.

c. Personal scrubs will not be accepted by TAMC laundry services except when soiled as above.

d. Uniforms and all other personal clothing items may be laundered at individual expense at the AAFES cleaners located in Wing 1C.

11-5. **Health Care, Health Insurance and Disability**.

a. As active duty service members, residents receive health care within the military system without cost. If required medical services cannot be obtained within the military system, the government will pay for those services outside of the military system.

b. Residents should choose a primary care manger (PCM) from among the staff of either the FMC or the internal medicine clinic. It is not recommended or encouraged for residents to care for other residents within TAMC.

c. Medical care for dependents of active duty soldiers is covered under the TRICARE system. Please see https://www.tricareonline.com/index.html for description of benefits.

d. Residents who become temporarily disabled through illness or injury continue to receive pay and benefits.

e. When illness or injury renders a resident unfit for further military service, as defined by AR 40-501, he or she undergoes the same medical board process as other soldiers, and if separated from the military receives benefits and separation pay as approved by the Physical Evaluation Board.

11-6. **Liability**.

a. A physician on active duty is covered for "liability protection" while acting within the scope of his/her employment.

b. Coverage for care delivered while on active duty continues even when the physician leaves the Army.

c. For further information, please consult with the hospital JAG office (433-5311) or refer to these sources:

(1) Medical Malpractice Immunity Act, 10 U.S.C. 1089 (1982).

(2) Federal Employee's Liability Reform and Tort Compensation Act of 1988, 28 U.S.C. 2679 (1988).

11-7. **Appointment and Residency Closure**.

a. Duration of appointment: Barring termination from the program for academic, legal, or health reasons, it is anticipated that physicians selected for internship will complete the entire 3-year residency program without interruption.

b. Residency closure or reduction. The Army may at any time reduce the number of residency slots at training program, or eliminate a GME program altogether, according to its own needs. In such cases, the Army will make every effort to allow residents continue their training at another facility, or if necessary, at a civilian institution.

Chapter 12 – Absences from Program

12-1. **American Board of Family Medicine Policy**.

a. Absence from training for longer than a month requires extension of training.

b. Vacation must be taken in the same year it is given. For example, a resident may not go without leave during the R2 year and take two months of leave as an R3.

c. Continuous absence for more than three months constitutes a breech of continuity of care and may require “additional continuity of patient care time beyond what is expected to complete training requirements in order to be eligible” for graduation.

12-2. **Departmental Policy**.

a. A resident who misses more than ten (10) consecutive days from a single rotation will be required to repeat the rotation except in unusual circumstances as determined by the PD.

b. Normally, a resident will be allowed only one week of absence from any rotation.

12-3. **What Counts as Time Away**?

a. Leave.

b. Reward pass.

c. Out processing time.

d. Sick leave: quarters, hospitalization and convalescence.

e. Maternity leave.

f. Paternity leave.

g. Adoption leave.

12-4. **What Does Not Count as Time Away**.

a. Administrative pass.

b. Five days TDY for professional meetings.

12-5. **Types of Absences**.

a. Ordinary Leave. Although service-members are allowed 30 days, the program restricts leave as follows:

(1) Interns are allowed two (2) weeks of leave and non-academic TDY including weekends.

(2) Interns may not take leave during the last 15 days of the academic year.

(3) R2s are allowed 28 days of leave and non-academic TDY.

(4) R3s are allowed 25 days of leave and non-academic TDY.

(5) R3s may not take leave during the last 15 days of the academic year.

(6) No resident may take leave during the in-training examination (typically, the first Friday of November).

(7) Leave can only be taken on approved rotations as indicated in attachment 1.

b. Reward Passes.

(1) Three or four day passes which include two (2) weekend days may be granted by the Troop Command for outstanding performance on the APFT or by the Chief, DFMEMS for other outstanding achievement.

(2) Reward passes can only be taken on rotations where leave is allowed.

(3) Reward passes count as time away from training.

(4) Reward passes cannot be used in conjunction with a leave.

c. Travel Passes (for travel to outer islands of Hawai'i).

(1) After call and work schedules have been posted, if a resident has no assigned duties for a weekend and wishes to travel to a neighbor island, she must request a travel pass.

(2) Soldiers may not travel to the neighbor islands without a travel pass.

(3) Travel passes do not count as time away from training.

(4) If a resident wants to ensure no duty on a particular weekend so that he may travel, he must submit a regular leave request.

d. TDY to attend professional meetings.

(1) A resident may request up to five days TDY in order to attend a professional meeting or conference.

(2) This TDY does not count as time away from the program.

(3) A resident cannot request permissive TDY to attend an educational conference.

e. Out-processing time.

(1) Departing residents are given five (5) days for packing and shipping personal effects, etc.

(2) These days count as time away from training.

(3) Proposed dates must be approved by the PD by 15 May.

(4) Proposed dates must be coordinated with the service the resident will rotate on at the time.

f. Sick Leave: quarters, hospitalization, and convalescent leave.

(1) A resident may only receive sick leave from a staff physician.

(2) When a resident requires sick leave he must notify the PD immediately.

(3) When possible, the resident should also notify the supervising staff of the rotation as well.

(4) Sick leave counts as time away from training.

g. Maternity leave.

(1) When a resident becomes pregnant, duty restrictions as detailed in paragraph 7-9, AR 40-501, Standards of Medical Fitness or as

specified by the resident's physician will be honored by the program. In particular, after 28 weeks of gestation the resident is exempt from call and works no more than 40 hours per week.

(2) A pregnant resident can expect postpartum convalescent leave of 42 days following hospitalization in accordance with AR 600-8-10, Leaves and Passes.

(3) Additional ordinary leave to be taken at the conclusion of postpartum convalescence may be approved at the discretion of the PD, and is subject to the implications of time away from training.

(4) Time spent away from work ante partum, intrapartum, and postpartum all counts as time away from training. In general, affected residents will require extension of training.

(5) With the approval of the PD, a resident may avoid extending her residency by arranging a single four-week "away" elective of home study.

(6) A resident should notify the PD as soon as is feasible that she is pregnant, in order to allow for appropriate planning and schedule accommodations.

h. Paternity leave.

(1) A resident is allowed to take as much leave as he has accrued following the birth of his child.

(2) A father will be granted time off to participate in the labor of his partner/wife and the birth of his child.

(3) The resident is responsible to notify his supervisor at the start of the rotation during which delivery is expected so that appropriate arrangements can be made.

(4) All the ABFM and departmental implications of time away from training apply to time off for the delivery and subsequent paternity leave.

(5) Notification of PD should occur as soon as is feasible to allow for appropriate planning and schedule accommodation.

i. Adoption leave.

(1) A resident adopting a child is allowed to take as much leave as he or she has accrued.

(2) All the ABFM and departmental implications of time away from training apply to adoption leave.

(3) The resident is required to notify the PD in a timely manner to allow for appropriate scheduling and leave approval.

j. Other leave policies.

(1) Residents must apply for leave, pass, and TDY using the electronic leave request form that is located on the department Internal Web site.

(2) Ordinary leave and reward pass requests must be submitted 60 days in advance. Other requests may be exempt from this requirement but should be submitted far enough in advance to allow appropriate scheduling.

(3) The PD must approve requests.

(4) The R3 in charge of scheduling plans the FM call schedule and coordinates with other departments on the basis of PD-approved requests.

(5) The residency coordinator generates the leave form (DA Form 31, Request and Authority for Leave) or TDY orders upon approval of chief resident and PD. Temporary Duty orders are processed through the Defense Travel System.

(6) A resident may not depart on leave or TDY unless she has in her possession a signed leave form or TDY orders.

(7) A resident who takes leave Monday through Friday is eligible for call the Saturday preceding and the Saturday or Sunday following the leave.

(8) A resident that works more than four hours the day he is to depart on leave is not charged for that day. Neither is that day counted as time away. In such cases, the resident is responsible to bring this to the attention of the residency coordinator.

(9) A resident must arrange coverage for her telephone consults, new results, and term OB patients and publicize these arrangements to the department prior to departing on leave.

Chapter 13 – Conduct and Ethics

13-1. **Standards of conduct**.

a. The Army's standards of conduct program is set forth in Department of Defense (DOD) Regulation 5500.7-R, Joint Ethics Regulation.

b. When in doubt contact your supervisor.

c. If further clarification is required, seek advice from the Staff Judge Advocate (433-5311).

13-2. **Specific Issues**.

a. Confidentiality – breech of these provisions can have serious legal consequences.

(1) Admissions and discussion of drug use, sexuality, and birth control for patients over 14 years of age are confidential and may not be disclosed to parents. Convenience medical files may be set up at their request.

(2) Spouses do not have any implied right to the medical information of their spouse, it must be given specifically.

(3) Commanders do have a right to the medical information of their soldiers.

(4) Answering machines are not considered confidential and messages with medical content should not be left on them.

(5) Physicians are not authorized to speak with news media concerning patients. Inquiries should be directed to PAO (the Public Affairs Office).

(6) Physicians are not authorized to speak with lawyers regarding patients or release patient information without first consulting the Staff Judge Advocate.

(7) Physicians are forbidden to access written or electronic medical information on any patient or colleague unless they are directly involved in the medical care of that individual.

b. Interaction with pharmaceutical representatives.

(1) Residents may accept gifts valued at $20 per occasion and $50 per year from a given company. These may include medical manuals, dinners where a speaker is featured, etc.

(2) Residents can accept a gift of any value gift, if that gift will be used for the good of all residents and is offered to any and all residents i.e. books for the residency library.

(3) It is the resident's responsibility to keep track of the value of gifts received.

(4) Residents must never solicit a gift – this is an ethical violation.

(5) Residents must never accept cash – this is an ethical violation.

(6) Residents must never accept drug samples.

(7) Drug companies and associations representing their interests frequently offer training courses to DA personnel. This type of training can be accepted only when the attendee is on official business with the government paying for transportation, per diem, and other reimbursable expenses. Only the cost of the actual training may be accepted from the company.

c. Senior/Subordinate relationships.

(1) Gifts to superiors must be voluntary and free of coercion, must commemorate some special occasion such as a wedding or retirement, and must cost less than $10 per individual and less than $300 total retail value.

(2) Commercial solicitation or sales to subordinates is forbidden. Sale of a privately owned home or non-commercial property is exempt from this rule.

(3) Department of the Army personnel must not use their official position to induce, coerce, or in any way influence any person, includ-

ing a subordinate, to provide unauthorized benefits, financial or otherwise. Use of rank or position to encourage a subordinate to participate in an investment opportunity would be an example of improper conduct.

(4) Sales and solicitations of cookies, candy, raffle tickets, Tupperware, etc. are forbidden in the clinic during duty hours. In addition, no such announcements are to be placed in mailboxes or made through CHCS or other electronic means.

d. Inappropriate use of the Internet.

(1) Visiting sexually explicit web sites will not be tolerated and doing so is punishable under the UCMJ.

(2) Tripler Army Medical Center has in place a system to detect attempted access to such web sites.

(3) The use of e-mail to deliberately propagate computer viruses is punishable under the UCMJ.

e. Remunerative professional civilian employment (moonlighting).

(1) Residents are forbidden to engage in remunerative civilian professional employment.

(2) Disobedience of this directive results in termination from the program.

f. Sexual Harassment.

(1) The program adheres to the Commanding General's Policy Memorandum 03 on sexual harassment.

(2) Violation of this policy is grounds for termination from the program or other disciplinary action.

g. Honoraria. Residents are forbidden to accept payment or anything of value for an appearance, speech, or published article.

h. The following behaviors will not be tolerated within the program:

(1) Disloyalty.

(2) Dishonesty.

(3) Disinterest.

(4) Disrespect.

Chapter 14 – Stress and Substance Abuse

14-1. **Stress Management**.

a. Stress is an inherent part of medical training. However, if left unchecked, it can lead to impairment.

b. The program is committed to the success of its trainees and the safety of its patients. Interns and resident will not be punished in any way for seeking help with stress or its effects.

c. Institutional measures in place to help residents cope with stress:

(1) Annual leave. Interns are allowed 14 days, R2s are allowed 28 days, and R3s are allowed 25 days plus 5 days for out-processing.

(2) Resident Support Group. Held weekly with the FM Behavioral Scientist.

(3) Internship stress management seminar held during FM orientation.

(4) Annual residency retreat designed for team building in a relaxed social atmosphere that includes families.

d. Resources for stress management:

(1) Advisors. Each resident is assigned a faculty mentor with whom she may discuss personal, administrative, or academic concerns at any time.

(2) Program Director.

(3) Department Behavioral Scientist.

(4) TAMC Psychology and Psychiatry clinics – both guarantee absolute confidentiality.

(5) Pearl Harbor and Hickam AFB psychology and psychiatry resources are also available to any resident who does not wish to receive consultation for mental health issues within the facility.

14-2. **Substance Abuse**.

a. All active duty soldiers are periodically tested for use of illegal drugs in a random fashion.

b. Any resident suspected to have a substance abuse problem is referred through the Army Substance Abuse Program (ASAP) for evaluation and treatment in accordance with AR 600-85, Army Substance Abuse Program (ASAP).

c. If a resident suspects a colleague or staff member of having a substance abuse problem, he must report that suspicion to the PD or the Chief, DFMEMS.

d. The TAMC Impaired Provider Subcommittee of the Credentials Committee oversees the hospital program for providers with substance abuse problems and has authority to restrict and restore practice privileges as appropriate.

Attachment 1 – Leave by Rotation

	Rotation	Allowed
First Year	FM Orientation	N
	FM Clinic	Y
	FMIT	N
	Pediatric Clinic	Y
	Newborn Nursery	N
	Pediatrics Ward	N
	Internal Medicine Ward	N
	SMICU	N
	ER	N
	L&D	Y
	OB Clinic	Y
	Surgery Ward	N
Second Year	FMIT	N
	Cardiology Inpatient Team (CIT)	N
	NICU	N
	Night Float	N
	Ortho Clinic	Y
	Psych Clinic	Y
	L&D	Y
	GYN Clinic	Y
	Dermatology Clinic	Y
	Urology / Colposcopy	Y
	Electives	Y
Third Year	FMIT	N
	High Risk OB	Y
	Community Medicine (CM)	Y
	Sports Medicine	Y
	Ortho Clinic	Y
	SMICU	N
	Night Float	N
	Ophtho/ENT Clinic	Y
	Surgery Clinic	Y
	Geriatrics - Center for Aging	Y
	Electives	Y